

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. 91

No. 200

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Cecil</i>	MARYLAND	STATE <i>Pa.</i>	COUNTY <i>Lancaster</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <i>Earlville</i>	LENGTH OF STAY (in this place) <i>just today</i>	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <i>Piquette, Pa.</i>	STREET ADDRESS (If rural, give location) <i>158-3</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS			
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) <i>Calvin Gordon Armstrong</i>		4. DATE OF DEATH (Month) (Day) (Year) <i>1 7 1956</i>	
5. SEX <i>M.</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, SEPARATED <i>Married</i>	8. DATE OF BIRTH <i>7-7-1883</i>
9. AGE last birthday: <i>72</i> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Carpenter</i>	
11. BIRTHPLACE (State or foreign country): <i>Lancaster Co. Pa.</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.</i>	
13. FATHER'S NAME: <i>Oliver Armstrong</i>		14. MOTHER'S MAIDEN NAME: <i>Susie McMillan</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY No.: <i>no</i>	
17. INFORMANT & ADDRESS: <i>Leonard Armstrong, Willow Street</i>			

18. MEDICAL CERTIFICATION		
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <i>Acute Coronary Thrombosis</i>		
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)		
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH		
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>M.</i>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE <i>Calvin Gordon Armstrong</i>		DATE SIGNED <i>1-7-56</i>
CHIEF MEDICAL EXAMINER <input type="checkbox"/> M. D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSISTANT MEDICAL EXAM. <input type="checkbox"/>		
23. BURIAL, CREMATION, REMOVAL (Specify): <i>buried</i>	DATE THEREOF <i>1/11/56</i>	NAME OF CEMETERY OR CREMATORY <i>Mt. Hope</i>
LOCATION (City, town, or county) (State) <i>Pa.</i>		
DATE REC'D BY LOCAL REG. <i>Jan. 7, 1956</i>	REGISTRAR'S SIGNATURE <i>Edward J. Holloway</i>	24. FUNERAL DIRECTOR <i>Edward J. Holloway</i>
ADDRESS <i>Willow Street</i>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 17 1956

BUREAU V. S.

478

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Cecil</u>	MARYLAND	STATE <u>New Jersey</u>	COUNTY <u>Salem</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>ELK Mills</u>	LENGTH OF STAY (in this place) <u>1 1/2 yrs.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Deep Water</u>	<u>X</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>		STREET ADDRESS (If rural give location) <u>106 Harrison St.</u>	<u>1</u>

3. NAME OF DECEASED: (Type or Print) <u>John Henry Aument</u>			4. DATE OF DEATH: <u>1 29 19 56</u>		
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>Sept. 24, 1889</u>		9. AGE last birthday: <u>66</u> yrs.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Machine Operator Dupont Chem. Co.</u>			10B. KIND OF BUSINESS OR INDUSTRY: <u>Maryland</u>		11. BIRTHPLACE (State or foreign country): <u>U.S.A.</u>
13. FATHER'S NAME: <u>George W. Aument</u>			14. MOTHER'S MAIDEN NAME: <u>ELLA B. Torbert</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u>		16. SOCIAL SECURITY NO.: <u>146-05-7741</u>		17. INFORMANT & ADDRESS: <u>George Aument, Newark, Del.</u>	

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE <u>420.1</u>	(A) <u>Cerebral thrombosis (2nd attack)</u>	<u>Nine</u>
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	(B) <u>Cerebral thrombosis (1st attack)</u>	<u>2 weeks</u>
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION: <u>0</u>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from <u>Dec 12</u> , 19 <u>55</u> , to <u>Jan. 29</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Jan. 13</u> , 19 <u>56</u> , and that death occurred at <u>5:30 P</u> M, from the causes and on the date stated above.			
SIGNATURE <u>J. Ralph Andrews Jr.</u>		DATE SIGNED <u>Jan. 30, 1956</u>	
ADDRESS <u>Elkton, Md.</u>		M. D. <u>Elkton, Md.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Buried</u>	DATE THEREOF <u>2/1/56</u>	NAME OF CEMETERY OR CREMATORY <u>Cherry Hill Methodist Ch.</u>	LOCATION (City, town, or county) (State) <u>Cherry Hill, Md.</u>
DATE REC'D BY LOCAL REGISTRAR <u>Feb 1</u>	REGISTRAR'S SIGNATURE <u>J. H. S. S. S.</u>	24. FUNERAL DIRECTOR <u>Walter B. B. B.</u>	ADDRESS <u>Elkton, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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FEB 2 1956
BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Cecil MARYLAND		STATE Md. COUNTY Cecil	
CITY (If outside corporate limits, write RURAL and give nearest town) X TOWN Liberty Grove Rural 75 yrs.		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Liberty Grove Rural	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (First) (Middle) (Last)			
Margaret Pearl Bancroft			
4. DATE (Month) (Day) (Year) OF DEATH: Jan. 9 1956			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:
Female	White	Widowed	Sept. 11, 1880
9. AGE last birthday		10. BIRTHPLACE (State or foreign country):	
75 yrs.		Liberty Grove Md.	
11. CITIZEN OF WHAT COUNTRY?		12. CITIZEN OF WHAT COUNTRY?	
U.S.		U.S.	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
Isaac Griest		Mary Caldwell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
No			
17. INFORMANT & ADDRESS:		18. MEDICAL CERTIFICATION	
Mrs. Ross Montgomery Liberty Grove		<p>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</p> <p>174 X IMMEDIATE CAUSE (A) Carcinoma Uterus -</p> <p>ANTECEDENT CAUSE (B) General Metastasis -</p> <p>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C) Myocarditis -</p>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY?		21. MEDICAL CERTIFICATION	
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</p> <p>3 yrs</p>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from June 19, 1954 to June 8, 1956 that I last saw the deceased alive on June 8, 1956 and that death occurred at 5:30 P.M. from the causes and on the date stated above.			
SIGNATURE J. E. Hanson		DATE SIGNED 1/11/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		24. FUNERAL DIRECTOR	
Burial		J. E. Hanson	
DATE THEREOF		ADDRESS	
Jan. 12, 1956		Rising Sun, Md.	
NAME OF CEMETERY OR CREMATORY		25. DATE REC'D BY LOCAL REGISTRAR	
Harmony Chapel Cem.		Jan 11-56	
LOCATION (City, town, or county) (State)		REGISTRAR'S SIGNATURE	
Rowlandville Md.		J. E. Hanson	

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN

Government (H. S. S.)
General Meeting
1/2/50
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BUREAU V. S.
JAN 12 1950

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information correct age is especially important. Physicians: please write the causes of death clearly and legibly.

480 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00461
Item 18 Film Q192 2-8-56 ans

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Cecil MARYLAND				STATE Maryland COUNTY Cecil			
CITY (If outside corporate limits, write RURAL OR, and give nearest town) Perry Point				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Perry Point (V.A. Hospital)			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hospital				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) ANTONIO (Middle) (NMI) (Last) BENEDITTO				4. DATE (Month) (Day) (Year) OF DEATH: January 27 19 56			
5. SEX: Male		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single		8. DATE OF BIRTH: 8-5-75	
9. AGE last birthday: 80 yrs.		10. KIND OF BUSINESS OR INDUSTRY: Unknown		11. BIRTHPLACE (State or foreign country): Italy		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Unknown				14. MOTHER'S MAIDEN NAME: Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes (If Yes, give war or dates of service) Philippine				16. SOCIAL SECURITY NO.: Unknown		17. INFORMANT & ADDRESS: Hospital Records, VAH, Perry Point, Md.	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) Hemorrhage subdural subarachnoid, massive						5 to 6 days	
ANTECEDENT CAUSE (S) due to trauma						5 to 6 days	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. Part II Fractures multiple, of the skull						7 to 10 days	
(C) Pneumonia lobar unresolved, right lower lobe						unknown	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Arteriosclerosis generalized							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY VA M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 3-3 , 19 24 to 1-27 , 19 56 , and that death occurred at 6:45 PM , from the causes and on the date stated above.							
SIGNATURE W. OPPLER, Director, Professional Services M.D. VAH, Perry Point, Md.				DATE SIGNED 1-31-56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 1-31-56		NAME OF CEMETERY OR CREMATORY Baltimore National		LOCATION (City, town, or county) (State) Baltimore, Md.	
DATE REC'D BY LOCAL REGISTRAR 2-1-56		REGISTRAR'S SIGNATURE Irma E. Dougherty		24. FUNERAL DIRECTOR Pennington & Son, Hayre de Grace, Md.			

RECEIVED

FEB 3 1956

BUREAU V. 2

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

481

CERTIFICATE OF DEATH

00462

Reg. Dist. No. 97

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Cecil</u>		MARYLAND		STATE <u>Indiana</u>		COUNTY <u>Ripley</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Bainbridge</u>		<u>3 days</u>		TOWN <u>Madison</u>		<u>52 x - 9</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital</u>				STREET ADDRESS (If rural give location) <u>R.D. #1</u>			
3. NAME OF DECEASED (Type or Print) <u>Gertrude Doll Benham</u>				4. DATE OF DEATH (Month) <u>1</u> (Day) <u>18</u> (Year) <u>19 56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>June 4, 1881</u>	9. AGE last birthday <u>74</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (State or foreign country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Deceased (unknown)</u>				14. MOTHER'S MAIDEN NAME <u>Deceased (unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) -----		16. SOCIAL SECURITY NO. -----		17. INFORMANT & ADDRESS <u>Navy Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A) <u>CEREBRAL VASCULAR ACCIDENT GENERALIZED</u>				INTERVAL BETWEEN ONSET AND DEATH <u>APPROX.</u>			
ANTECEDENT CAUSE(S) DUE TO <u>ARTERIOSCLEROSIS</u>				<u>3 days</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. -----							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1-15</u> , 19 <u>56</u> , to <u>1-18</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1-18</u> , 19 <u>56</u> , and that death occurred at <u>4:10 P.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>D. H. Till Lt MC USNR</u>				ADDRESS (Street, city, town, state) <u>M.D. USNH, Bainbridge, Maryland</u> DATE SIGNED <u>1-19-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal & Burial</u>		DATE THEREOF <u>1-19-56</u>		NAME OF CEMETERY OR CREMATORY <u>Benham Cemetery</u>		LOCATION (City, town, or county) (State) <u>Benham, Indiana</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Dorothy B. Bramble</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Patterson</u>		ADDRESS <u>Perryville, Md</u>	
DATE <u>1-18-56</u>							

CERTIFICATE OF DEATH

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BUREAU V. 1

JAN 23 1956

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MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
 191

482
CERTIFICATE OF DEATH

Reg. Dist. No. 46

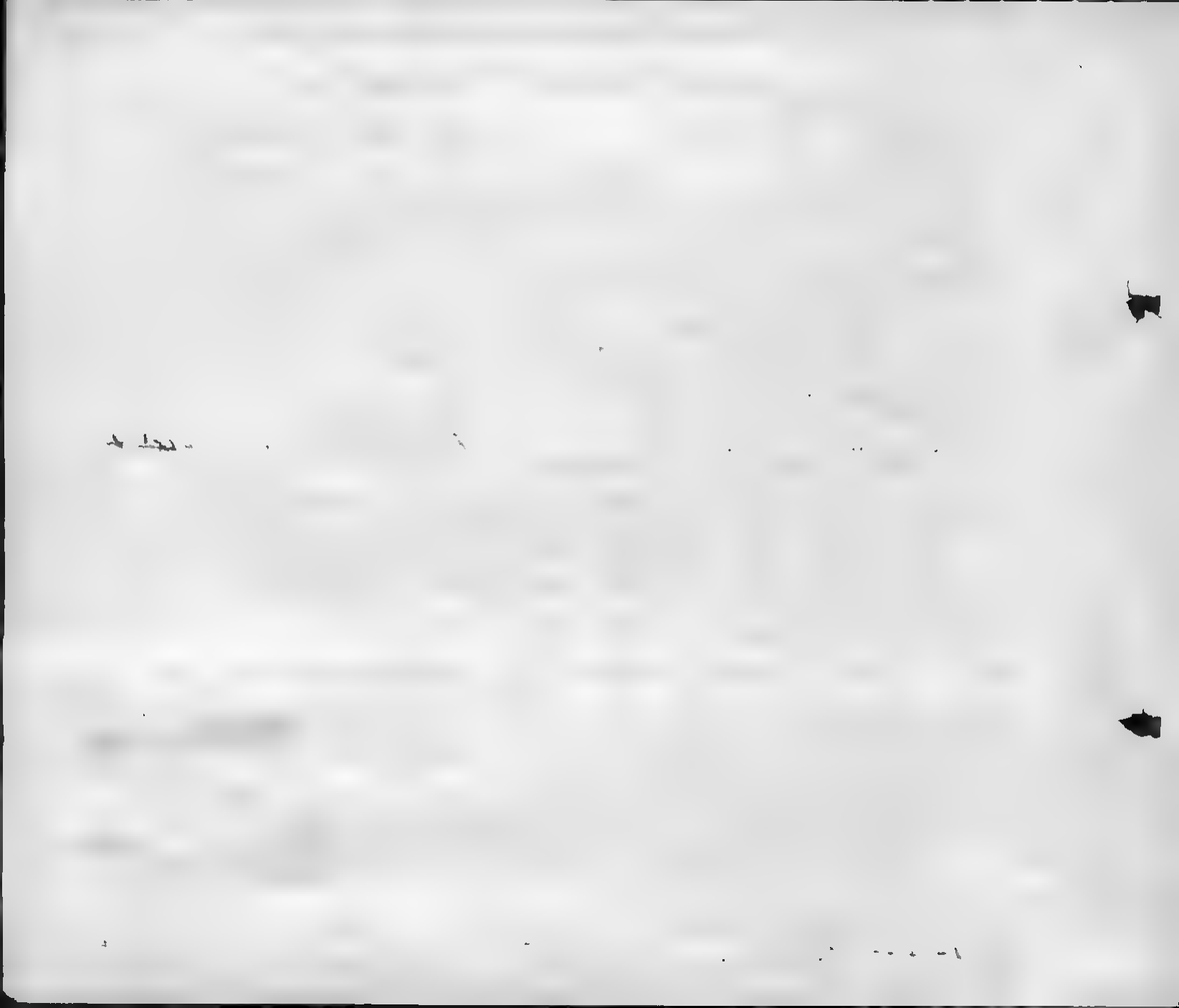
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Cecil		MARYLAND		STATE Md		COUNTY Cecil	
CITY OR TOWN Port Deposit		LENGTH OF STAY (in this place) Life		CITY OR TOWN Port Deposit		(If outside corporate limits, write RURAL and give nearest town)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Rock Run				STREET ADDRESS (If rural give location) Rock Run			
3. NAME OF DECEASED (Type or Print) George Body				4. DATE OF DEATH JAN - 19 1956			
5. SEX Male	6. COLOR OR RACE Col -	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH NOV - 28 1868	9. AGE last birthday 87 yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LUMBER		10b. KIND OF BUSINESS OR INDUSTRY GENERAL		11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Rev. George J. Body				14. MOTHER'S MAIDEN NAME Nancy O. Jones			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Estelle Jennifer Port Deposit Md	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A) Cerebral Hemorrhage				INTERVAL BETWEEN ONSET AND DEATH 5 days			
ANTECEDENT CAUSE(S) DUE TO (B) Paralysis Rt Side							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Arterio - Sclerosis				8 yrs -			
19. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Nov - 19 1955 to Jan 19 1956, that I last saw the deceased alive on Jan 19 1956, and that death occurred at 9 A.M. from the causes and on the date stated above.							
SIGNATURE E. Benson				DATE SIGNED 1/20/56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				DATE THEREOF 1-21-1956		NAME OF CEMETERY OR CREMATORY Mt Zoar	
24. REC'D BY REGISTRAR				REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE	
DATE 1-22-1956				J. E. Benson		Lee A. Patterson & Son, Perryville Md	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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467

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Cecil</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>ELKTON</u>		LENGTH OF STAY (in this place) <u>1 day</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>rural Elkton RD 3</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Union Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Robert Allen BRINKLEY</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>1 24 1956</u>			
5. SEX. <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>		8. DATE OF BIRTH: <u>Sept. 23, 1956</u>	
9. AGE last birthday <u>4</u> yrs.		10. UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>				10B. KIND OF BUSINESS OR INDUSTRY:			
13. FATHER'S NAME: <u>William T. Brinkley</u>				14. MOTHER'S MAIDEN NAME: <u>Flossie Murdock</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT & ADDRESS: <u>William T. Brinkley</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						2 weeks	
IMMEDIATE CAUSE (A) <u>Pertussis</u>							
ANTECEDENT CAUSE (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan. 17</u> , 1956, to <u>Jan. 24</u> , 1956, that I last saw the deceased alive on <u>Jan. 23</u> , 1956, and that death occurred at <u>7:15 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>S. Ralph Andrews Jr.</u>				ADDRESS <u>Elkton Maryland</u>		DATE SIGNED <u>1/24/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/26/56</u>		NAME OF CEMETERY OR CREMATORY <u>Elkton Cemetery</u>		LOCATION (City, town, or county) (State) <u>Elkton Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Jan 26</u>		REGISTRAR'S SIGNATURE <u>J.R. Brazner</u>		24. FUNERAL DIRECTOR <u>H. Walter du Bose Jr</u>		ADDRESS <u>Elkton, Md.</u>	

U. A. 10712

90

60

483

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Cecil</u>		MARYLAND		STATE <u>Virginia</u> COUNTY <u>Halifax</u>			
CITY (If outside corporate limits, write RURAL and give nearest town.)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
TOWN <u>Perry Point</u>		<u>4 yrs. 19 days</u>		Clover			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>RFD# 1, Box 125</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH			
<u>WILLIAM B. CARRINGTON</u>				<u>January 27, 1956</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH.	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 MRS.	
<u>Male</u>	<u>Negro</u>	<u>Married</u>	<u>Oct. 26, 1895</u>	<u>60 yrs.</u>	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):			10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Farmer</u>			<u>self-employed</u>	<u>Virginia</u>		<u>USA</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>JESSE CARRINGTON</u>				<u>GEORGINNA EASLEY</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS:	
<u>Yes</u> <u>WW-I</u>				<u>Unknown</u>		<u>Hospital Records, VAH., Perry Point, Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A)				<u>Auricular fibrillation</u>		<u>1 hr.</u>	
ANTECEDENT CAUSE (B)				<u>Cardiac arrest</u>		<u>15-20 min.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				<u>Lobectomy, left upper lobe</u>		<u>2 hrs.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						<u>unknown</u>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan. 8, 1952</u> , to <u>Jan. 27, 1956</u> , the deceased was <u>not</u> a patient of the VA, and that death occurred at <u>2:43 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>W. Oppler</u>		ADDRESS		DATE SIGNED			
<u>W. OPPLER, M.D.</u>		<u>Director, Professional Services, VAH., Perry Point, Md.</u>		<u>1-29-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>REMOVAL</u>		<u>1-29-56</u>		<u>Unknown</u>		<u>Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>1-29-56</u>		<u>Irma E. Dougherty</u>		<u>Warrington & Son</u>		<u>Harre D. eGrace, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 1 1900

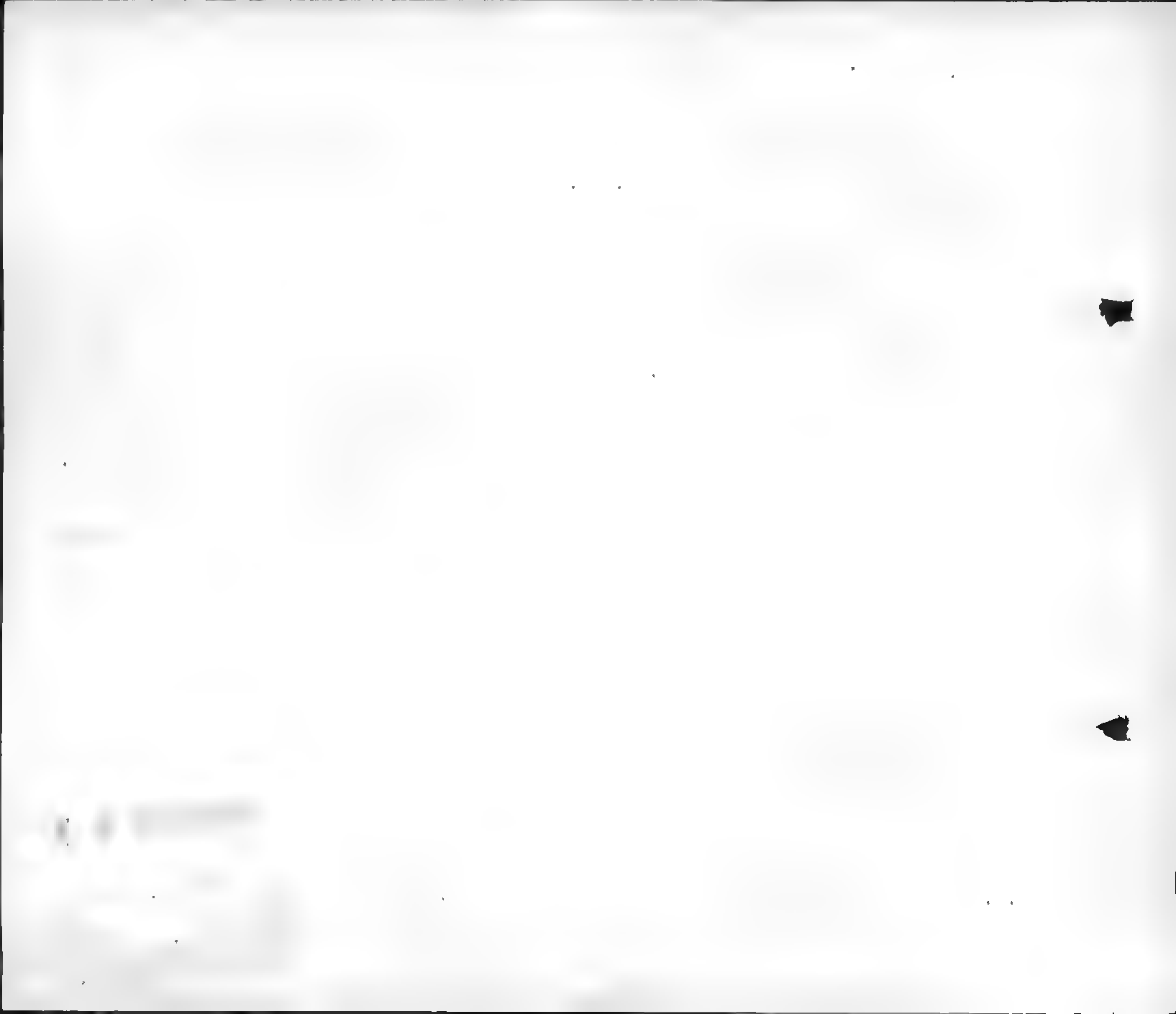
BUREAU V. S.

484

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH.		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Cecil	MARYLAND	STATE Maryland	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town) X TOWN Perry Point	LENGTH OF STAY (in this place) 26yrs. 4mo. 13days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hospital		STREET ADDRESS (If rural give location) 617 Grantley	
3. NAME OF DECEASED: (First) (Middle) (Last) GEORGE W. COOK		4. DATE (Month) (Day) (Year) OF DEATH: January 10 19 56	
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single	8. DATE OF BIRTH: 8-18-93
9. AGE last birthday 62 yrs.		10. IF UNDER 1 YEAR: Months Days	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Brakeman		10B. KIND OF BUSINESS OR INDUSTRY: Penna. Railroad	
11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Joseph Cook		14. MOTHER'S MAIDEN NAME: Isabella Griffith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT & ADDRESS: Hospital Records, VAH, Perry Point, Md.			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) Tuberculosis of the lungs bilateral, with			unknown
ANTECEDENT CAUSE (S) DUE TO chronic adherent pleurisy, left			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (B) Coronary arteriosclerosis, moderately			unknown
(C) Cirrhosis of the liver			unknown
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY VA M.	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 8-28, 1929, to 1-10, 1956, and that death occurred at 6:30 A.M. from the causes and on the date stated above.			
SIGNATURE J.C. Grasberger, Acting Director, Professional Services		DATE SIGNED 1-12-56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal	DATE THEREOF 1-12-56	NAME OF CEMETERY OR CREMATORY Baltimore National	LOCATION (City, town, or county) (State) Baltimore, Md.
DATE REC'D BY LOCAL REGISTRAR 1-12-56	REGISTRAR'S SIGNATURE Irene E. Dougherty	24. FUNERAL DIRECTOR Pennington & Sons, 4000 de Grace, Md.	



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CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u> Cecil </u>	MARYLAND	STATE <u> Md. </u>	COUNTY <u> Cecil </u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u> Elkton </u>	LENGTH OF STAY (in this place) <u> 30 yrs. </u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u> Elkton - </u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location) <u> 212 W. Main Street </u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u> John Howard Davis </u>		4. DATE (Month) (Day) (Year) OF DEATH <u> Jan. 17th 1956 </u>	
5. SEX: <u> male </u>	6. COLOR OR RACE: <u> white </u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u> widower </u>	8. DATE OF BIRTH: <u> June 14-1866 </u>
9. AGE last birthday <u> 89 </u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u> Farming </u>		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country): <u> Cecil County Md. </u>		12. CITIZEN OF WHAT COUNTRY? <u> U.S.A. </u>	
13. FATHER'S NAME: <u> James Thomas Davis </u>		14. MOTHER'S MAIDEN NAME: <u> Louisa Metcalf </u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service) <u> no </u>		16. SOCIAL SECURITY NO.	
17. INFORMANT'S ADDRESS: <u> Mrs. Russell George daughter - Elkton - Md. </u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u> General Arteriosclerosis </u>			<u> 5 years </u>
ANTECEDENT CAUSE (B) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u> Jan 25, 1950 </u> to <u> Jan 17th, 1956 </u> that I last saw the deceased alive on <u> Jan 17th, 1956 </u> and that death occurred at <u> 3:05 P.M. </u> from the causes and on the date stated above.			
SIGNATURE <u> J. H. Knight </u>		DATE SIGNED <u> Jan 18-56 </u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u> Burial </u>		DATE THEREOF <u> 1-21-56 </u>	
NAME OF CEMETERY OR CREMATORY <u> Cherry Hill Cemetery </u>		LOCATION (City, town, or county) (State) <u> Cherry Hill Md. </u>	
DATE REC'D BY LOCAL REGISTRAR <u> Jan 21 </u>		REGISTRAR'S SIGNATURE <u> J. H. Knight </u>	
24. FUNERAL DIRECTOR <u> Pappin Funeral Home </u>		ADDRESS <u> 259 E. Main St. Elkton Md. </u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Age Group	No	Not sure	Yes	Probably yes	Probably no
18-24	10	15	10	5	15
25-34	10	15	15	10	10
35-44	10	15	20	15	10
45-54	10	15	25	20	10
55-64	10	15	30	25	10
65+	10	15	45	25	5

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

485
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. ...

00468
Reg. Dist.

1. PLACE OF DEATH: COUNTY <u>Becil</u> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) <input checked="" type="checkbox"/> TOWN <u>Coronungo</u> RD. <u>67th</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Md.</u> COUNTY <u>Becil</u> CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Coronungo Rural</u> STREET ADDRESS (If rural, give location) <u>1</u>			
3. NAME OF DECEASED: (Type or Print) <u>LOLA</u> (First) <u>BELLE</u> (Middle) <u>DAVIS</u> (Last)				4. DATE OF DEATH (Month) <u>1</u> (Day) <u>16</u> (Year) <u>1956</u>			
5. SEX: <u>F.</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED: <u>Married</u>		8. DATE OF BIRTH: <u>7-2-1890</u>	
9. AGE last birthday: <u>65</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Housewife</u>		11. BIRTHPLACE (State or foreign country): <u>Ash. Co N.C.</u>	
12. CITIZEN OF WHAT COUNTRY: <u>U.S.</u>		13. FATHER'S NAME: <u>Jarris Jones</u>				14. MOTHER'S MAIDEN NAME: <u>Bethana Phipps</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no</u>		16. SOCIAL SECURITY No.: <u>none</u>		17. INFORMANT & ADDRESS: <u>Elongo Davis Coronungo Md</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: <u>420.11</u> Immediate cause <u>Acute Coronary Occlusion</u> DUE TO Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>W. L. Woodson</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>1-17-56</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <u>Y. E. Clark Tyson, Rising Sun Md</u>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>13 burial</u>		DATE THEREOF: <u>Jan 19 1956</u>		NAME OF CEMETERY OR CREMATORY: <u>Coronungo Baptist Cem</u>		LOCATION (City, town, or county) (State): <u>Coronungo Cecil Md</u>	
DATE RECD. BY LOCAL REG. <u>Jan 17-56</u>		REGISTRAR'S SIGNATURE: <u>L. M. Worthington</u>		24. FUNERAL DIRECTOR: <u>Y. E. Clark Tyson, Rising Sun Md</u>			
ADDRESS		ADDRESS					

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00469

486

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Cecil</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Harford</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Perryville</u>		LENGTH OF STAY (in this place) <u>1 month 2 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cardiff</u> <u>12X-2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Adm. Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Paul R. Donnan</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>Jan. 13, 1956</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>4-27-89</u>	9. AGE last birthday <u>66</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Manager</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Theater</u>		11. BIRTHPLACE (State or foreign country): <u>Whiteford, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>James A. Donnan</u>				14. MOTHER'S MAIDEN NAME: <u>Elizabeth Lane</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>WWI</u>		16. SOCIAL SECURITY NO. <u>215 16 0416</u>		17. INFORMANT & ADDRESS: <u>Hospital Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>260X Arteriolar nephrosclerosis.</u>						4 years	
ANTECEDENT CAUSE (S) DUE TO (B) <u>Diabetes Mellitus</u>						5 years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>12/11/</u> , 19 <u>55</u> , to <u>1/13/</u> , 19 <u>56</u> , that I attended the deceased and that death occurred at <u>10:55 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		ADDRESS <u>Acting Director, Professional Services, VAH., Perry Point, Md.</u>		DATE SIGNED <u>1/14/56</u>			
23. REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>1-14-56</u>		NAME OF CEMETERY OR CREMATORY <u>Slate Ridge</u>		LOCATION (City, town, or county) (State) <u>Delta, Pa.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1-14-56</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>H. HARKINS</u>		ADDRESS <u>Delta, Pa.</u>	

BUREAU 1. 2

JAN 17 1956

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

469
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00470

Reg. Dist.

No. 92.....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Cecil</u>		MARYLAND		STATE <u>Ind.</u>		COUNTY <u>Cecil</u>	
CITY (If outside corporate limits write RURAL OR and give nearest town) <u>Elkton</u>		LENGTH OF STAY <u>8-17-56</u>		CITY (If outside corporate limits write RURAL and give nearest town) <u>Elk Mills</u>		TOWN <u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Union Hosp. D.O.A.</u>				STREET ADDRESS (If rural, give location) <u>1</u>			
3. NAME OF DECEASED: (Type or Print)		(First) <u>Richard</u> (Middle) <u>Harmon</u> (Last) <u>Dove, Jr.</u>		4. DATE OF DEATH		(Month) <u>1</u> (Day) <u>14</u> (Year) <u>1956</u>	
5. SEX <u>Mr.</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH: <u>Aug 14 1906</u>	9. AGE last birthday: yrs. <u>5</u>		IF UNDER 1 YEAR Months <u>3</u> Days <u>5</u> Hours <u>1</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Inspector</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Elkton Ind.</u>		11. BIRTHPLACE (State or foreign country): <u>U.S.C.</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.C.</u>	
13. FATHER'S NAME: <u>Richard Harmon Dove, Jr.</u>				14. MOTHER'S MAIDEN NAME: <u>Bessie Loraker</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No.: <u>—</u>		17. INFORMANT & ADDRESS: <u>Richard H. Dove Jr. Elk Mills</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
085.1 Immediate cause (a) <u>Bronchio Pneumonia</u> DUE TO							
Antecedent cause(s) (b) <u>3 day measles</u> DUE TO							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>R. L. Woodson</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <u>1-14-56</u>					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>1/16/56</u>		NAME OF CEMETERY OR CREMATORY <u>Elkton Cemetery</u>		LOCATION (City, town, or county) (State) <u>Elkton Md.</u>	
DATE REC'D BY LOCAL REG. <u>Jan 16</u>		REGISTRAR'S SIGNATURE <u>JR. Frager</u>		24. FUNERAL DIRECTOR <u>E. W. Altman & Sons, Jr. Elkton, Md.</u>			

BUREAU A

NOV 17 1905

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 104

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

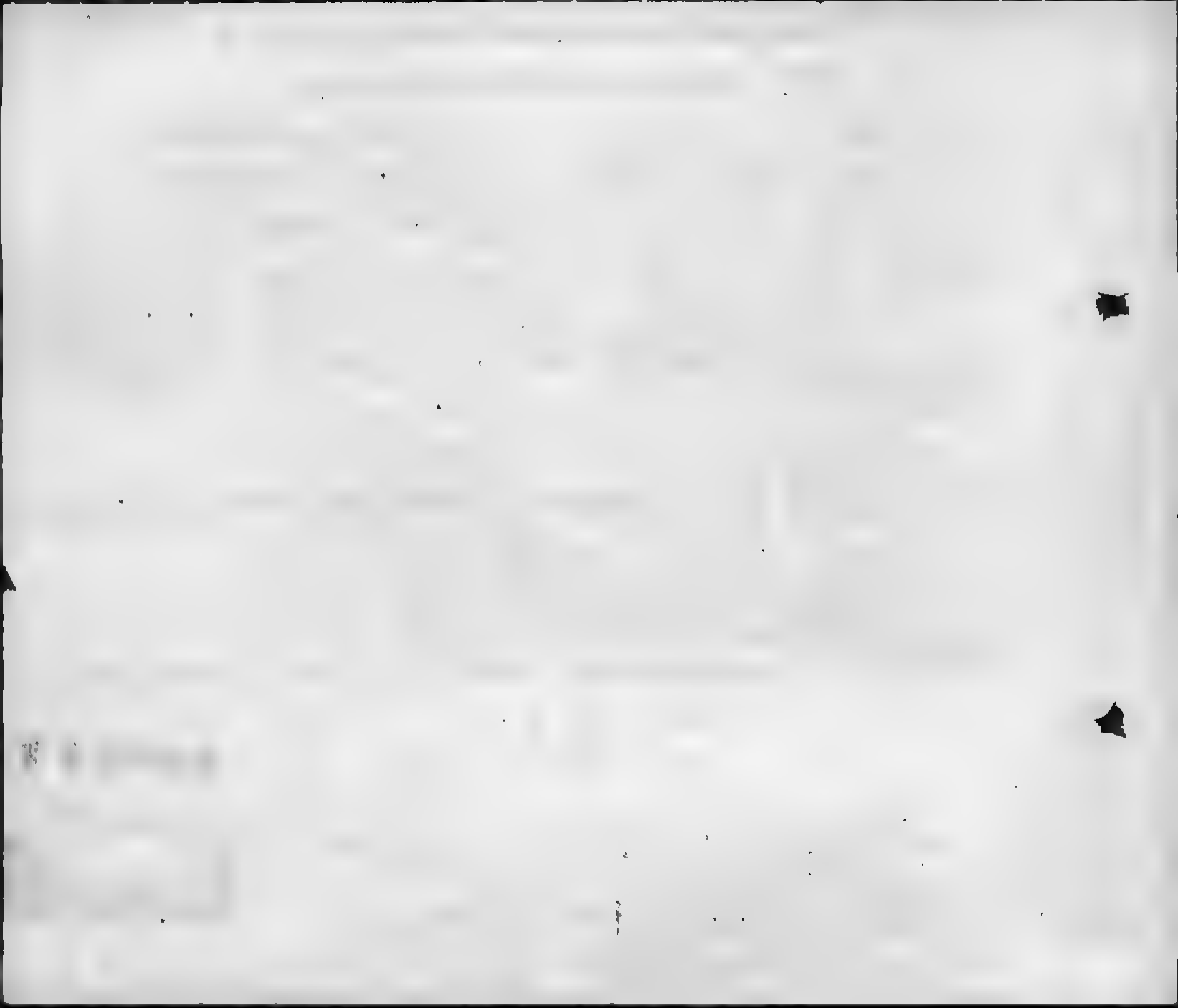
00471

470

CERTIFICATE OF DEATH

Reg. Dist. No. 200 Kent

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Cecil		MARYLAND		STATE MD.		COUNTY Cecil	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Elkton		Life		TOWN Rural Earleville			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Union Hospital				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) Harry Duff				4. DATE OF DEATH (Month) (Day) (Year) Jan. 4. 1956			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH May 9, 1896	9. AGE last birthday 59 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Labor		10b. KIND OF BUSINESS OR INDUSTRY Farm Work		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Duff				14. MOTHER'S MAIDEN NAME Margaret J. Culley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. 215 32 1633		17. INFORMANT & ADDRESS Thomas Duff Earleville Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.0 IMMEDIATE CAUSE (A) Massive Myocardial Infarction				INTERVAL BETWEEN ONSET AND DEATH 7 min			
ANTECEDENT CAUSE(S) DUE TO (B) Coronary Atherosclerosis				7 min			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Arteriosclerotic Heart Disease				year.			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Pulmonary Embolism				4 days.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 25, 1955, to Jan 56, 1956, that I last saw the deceased alive on Jan 4, 1956, 1956, and that death occurred at 11:25 A.M. from the causes and on the date stated above.							
SIGNATURE Wallace Ovenshain		M.D. Cecilton Md.		ADDRESS (Street, city, town, state)		DATE SIGNED Jan 56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Jan. 7. 1956		NAME OF CEMETERY OR CREMATORY Cecilton Cemetery		LOCATION (City, town, or county) Cecilton Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Edward T. Halloway		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE 1/6/56							



487

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED.	
COUNTY <u>CECIL</u>	MARYLAND	STATE <u>PENNSYLVANIA</u> COUNTY <u>ALLEGHENY</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>PERRY POINT, MD.</u>	LENGTH OF STAY (in this place) <u>24yrs2mos7days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>PITTSBURGH</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>VETERANS ADMINISTRATION HOSPITAL</u>	STREET ADDRESS (If rural give location) <u>438 Cadet Avenue</u>		
3. NAME OF DECEASED: (First) (Middle) (Last) <u>JOSEPH J. FLEISNER</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>January 14 1956</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Divorced</u>	8. DATE OF BIRTH: <u>March 20, 1896</u>
9. AGE last birthday <u>59</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Unk.</u>		12. BIRTHPLACE (State or foreign country): <u>Penna.</u>	
13. FATHER'S NAME: <u>AUTHOR FLEISNER</u>		14. MOTHER'S MAIDEN NAME: <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service) <u>Yes WW-I</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT & ADDRESS: <u>Hospital Records, VAH., Perry Point, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Bronchopneumonia, unresolved, left lower lobe.</u>		<u>3-5 days</u>	
ANTECEDENT CAUSE (B) <u>Arteriosclerosis with narrowing of coronary artery.</u>		<u>Unknown</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Arteriosclerosis, general</u>		<u>Unknown</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov. 7, 1931</u> to <u>Jan. 14, 1956</u> , and that death occurred at <u>4:05 A.M.</u> from the causes and on the date stated above.			
J. C. GRUBB, Acting Director Professional Services, VAH., Perry Point, Md. 1/15/56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
DATE THEREOF <u>1-15-56</u>		<u>Unknown</u>	
LOCATION (City, town, or county) (State)		<u>Unknown Pittsburgh Pa.</u>	
24. FUNERAL DIRECTOR		ADDRESS	
DATE REC'D BY LOCAL REGISTRAR <u>1-16-56</u>		REGISTRAR'S SIGNATURE <u>James E. Dougherty</u>	
PENNINGTON & SON, Havre DeGrace, Md.			

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

U.S. AIR FORCE

100-100000

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

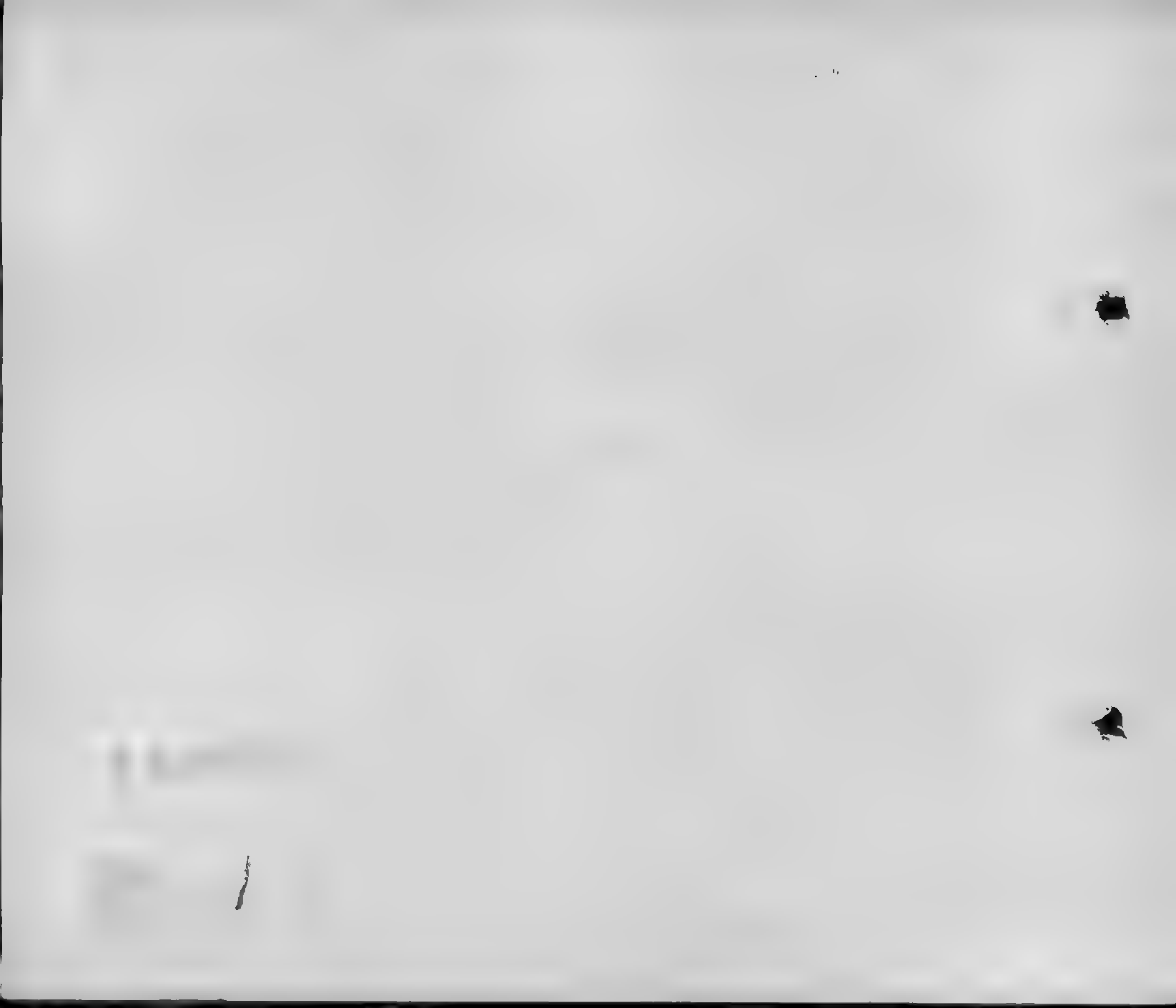
488
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00473

Reg. Dist.

No. 94

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>ecil</i>	MARYLAND	STATE <i>Ky.</i>	COUNTY <i>Boyd.</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <i>Leaside</i>	LENGTH OF STAY (In days) <i>1 day</i>	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <i>Leaside</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Silvers Cannery.</i>		STREET ADDRESS (If rural, give location) <i>1</i>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <i>ERNEST</i> (Middle) (Last) <i>HART</i>		(Month) <i>1</i> (Day) <i>8</i> (Year) <i>1956.</i>	
5. SEX: <i>M.</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <i>Single.</i>	8. DATE OF BIRTH: <i>June 9, 1906</i>
9. AGE last birthday: <i>49</i> yrs		10. IF UNDER 1 YEAR: Months <i>5</i> Days <i>10</i> Hours <i>0</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <i>Cannery</i>		11. BIRTHPLACE (State of foreign country): <i>Kentucky</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>		13. FATHER'S NAME: <i>Texanna Hart</i>	
14. MOTHER'S MAIDEN NAME: <i>Foreman Silver Cannery Leaside Ind.</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	
16. SOCIAL SECURITY No: <i>402-05-4759</i>		17. INFORMANT & ADDRESS:	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
(a) Immediate cause <i>Charred body.</i>			
(b) Antecedent cause(s) <i>giving rise to the above cause stating underlying cause last</i>			
(c) DUE TO			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, street, office, hotel, etc., INJURY) <i>Leaside Cecil Ind.</i>	
21c. (City or town) (County) (State)		21d. HOW DID INJURY OCCUR? <i>Overheated Oil heater</i>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>1 8 56 1956</i>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <i>R. L. Dodson</i>		M. D. ASSISTANT MEDICAL EXAM. <i>1-9-56</i>	
23. BURIAL, CREMATION, REMOVAL (Specify): <i>Burial</i>		DATE THEREOF <i>1-10-1956</i>	
NAME OF CEMETERY OR CREMATORY <i>Methodist</i>		LOCATION (City, town, or county) (State) <i>North East Ind.</i>	
DATE REC'D BY LOCAL REG. <i>Jan 10-1956</i>		REGISTRAR'S SIGNATURE <i>Sarah E. Rothmell</i>	
FUNERAL DIRECTOR <i>Joseph R. Grant</i>		ADDRESS <i>North East Ind.</i>	



1 TO ATTENDING PHYSICIAN OR HOSPITAL: The bottom copy may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00474

471

CERTIFICATE OF DEATH

Reg. Dist. No. 97

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Cecil		STATE Md		COUNTY Cecil			
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN ELKTON		61 years		TOWN ELKTON			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
108 Church St.				108 Church Street			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
PERRY BARNES HEVERIN, JR.				1 24 1956			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
M	W	MAR	8.3.1894	61 yrs.	Months Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Chauffeur		Md. State Rds		Maryland		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
PERRY B. HEVERIN Sr.				Josephine LAMAR			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No				Mrs. Perry Heverin, Jr. Elkton, Md.			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				16. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A)				CONGESTIVE HEART FAILURE			
ANTECEDENT CAUSE(S) DUE TO				MASSIVE MYOCARDIAL OCCLUSION			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO				ARTERIOSCLEROSIS (coronary hardening)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				Chronic kidney insufficiency			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		INTERVAL BETWEEN ONSET AND DEATH			
				2 months			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1.27.1955, to 1.24.1956, that I last saw the deceased alive on 1.24.1956, and that death occurred at 2:05 A.M. from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
Perry Heverin, Jr.				1.24.56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		1/27/56		Elkton Cemetery		Elkton Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Jan. 27, 1956		F. R. Lingers		H. Walter du Bose		Elkton Md.	

1/2 of 1/2

489

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Cecil		MARYLAND		STATE D. C.		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Ferry Point		LENGTH OF STAY (in this place) 9 days		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hospital				STREET ADDRESS (If rural give location) 5344 Grant Street, N.E.			
3. NAME OF DECEASED: (First) GEORGE		(Middle) N.		(Last) HILL		4. DATE (Month) (Day) (Year) OF DEATH: January 5 19 56	
5. SEX: Male	6. COLOR OR RACE: Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married	8. DATE OF BIRTH: 10-4-98	9. AGE last birthday: 57 yrs.	IF UNDER 1 YEAR: Months	IF UNDER 24 HRS.: Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer		10B. KIND OF BUSINESS OR INDUSTRY: Unknown		11. BIRTHPLACE (State or foreign country): Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: George Hill - Deceased				14. MOTHER'S MAIDEN NAME: Estelle Stewart - Deceased			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes		(If Yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT & ADDRESS: Hospital Records, VAH, Perry Point, Md.	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE		(A) Hemorrhage inter abdominal				1 day	
ANTECEDENT CAUSE (S)		DUE TO Cirrhosis of the liver				Approx. 2 yrs.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.						(B) DUE TO	
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: 5		19B. MAJOR FINDINGS OF OPERATION					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY VA M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 12-27, 1955, to 1-5-1956, and that death occurred at 5:00 AM, from the causes and on the date stated above.							
SIGNATURE W. OPPLER, Director, Professional Services, M.D. VAH, Perry Point, Md.		ADDRESS		DATE SIGNED 1-5-56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		DATE THEREOF 1-5-56		NAME OF CEMETERY OR CREMATORY Arlington National		LOCATION (City, town, or county) (State) Arlington, Va.	
DATE REC'D BY LOCAL REGISTRAR 1-5-56		REGISTRAR'S SIGNATURE James E. Langharty		24. FUNERAL DIRECTOR Hoffman's Fun. Home, 611 K. St., N.W. Wash. D.C.		ADDRESS	

MARGIN RESERVED FOR BINNING

VS. A15 — 10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

Reg. Dist. No. 92

Item 8, Film G192 2-1-56 et

1. PLACE OF DEATH:

COUNTY CECIL MARYLAND
 CITY (If outside corporate limits, write RURAL OR and give nearest town) ELKTON LENGTH OF STAY (in this place) 2 days
 HOSPITAL OR INSTITUTION OR STREET ADDRESS Union Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MD COUNTY CECIL
 CITY (If outside corporate limits, write RURAL and give nearest town) ELKTON
 STREET ADDRESS (If rural give location) 202 BLUE BALL STR.

3. NAME OF DECEASED:

(First) ANNIE (Middle) V. (Last) HOLMES
 (Type or Print)

4. DATE OF DEATH: (Month) 1 (Day) 22 (Year) 1956

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MAR.

8. DATE OF BIRTH: Nov. 10, 1881

9. AGE last birthday: 74 yrs. Months: Days: Hours: Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): PHILADELPHIA, PA.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME:

JAMES McDONALD

14. MOTHER'S MAIDEN NAME:

Mrs. Ester Rittenhouse, Elkton, Md.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No

16. SOCIAL SECURITY No.: —

17. INFORMANT & ADDRESS:

Mrs. Ester Rittenhouse, Elkton, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) MASSIVE CEREBRAL HEMORRHAGE

Interval Between Onset And Death

2 days

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

CVA

2 days

(c)

CEREBRAL VASCULAR SCLEROSIS

5-6 years

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

DIABETES MELLITUS

20 years?

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1.17, 1956, to 1.22, 1956, that I last saw the deceased

alive on 1.22, 1956, and that death occurred at 8 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Jan 23

H. H. Hager

Joseph R. Hunt North East Md

W. A. RYAN

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH COUNTY Cecil MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) Elkton TOWN Elkton HOSPITAL OR INSTITUTION OR STREET ADDRESS 404 North St.				2. USUAL RESIDENCE (HOME) OF DECEASED STATE Md. COUNTY Cecil CITY (If outside corporate limits, write RURAL and give nearest town) Elkton TOWN Elkton STREET ADDRESS (If rural give location) 404 North St.			
3. NAME OF DECEASED (Type or Print) Julia A Juergens			4. DATE OF DEATH (Month) (Day) (Year) JAN 1 1956				
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWER, DIVORCED, (Specify) WIDOW	8. DATE OF BIRTH Aug. 18, 1865	9. AGE last birthday 90 yrs.	IF UNDER 1 YEAR Months Days		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home			10b. KIND OF BUSINESS OR INDUSTRY House wife	11. BIRTHPLACE (State or foreign country) Ireland			
13. FATHER'S NAME Benard Pryer			14. MOTHER'S MAIDEN NAME Susan Mulvaney				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mrs Emma Kincaid Elkton, Md.		
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 442X IMMEDIATE CAUSE (A) Pulmonary edema ANTECEDENT CAUSE(S) DUE TO (B) Cardiovascular renal DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)					INTERVAL BETWEEN ONSET AND DEATH 2 days 10 years		
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 12/31, 1955 to 1/1, 1956, that I last saw the deceased alive on 12/31, 1955, and that death occurred at 5:30 A.M. from the causes and on the date stated above. SIGNATURE J. Rodney Pryer M.D. Elkton Md. ADDRESS (Street, city, town, state) DATE SIGNED 1/2/56							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF Jan 4/56	NAME OF CEMETERY OR CREMATORY Catholic		LOCATION (City, town, or county) (State) Elkton Md			
24. REC'D. BY REGISTRAR JAN 5 1956		REGISTRAR'S SIGNATURE J. Rodney Pryer		25. FUNERAL DIRECTOR'S SIGNATURE Pippin Funeral Home			
				ADDRESS Elkton, Md.			

By Pippin

BUDGET V. S.

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RECEIVED

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CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Cecil		MARYLAND		STATE Md		COUNTY Cecil	
CITY (if outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (if outside corporate limits, write RURAL and give nearest town)			
TOWN Port Deposit		Life		TOWN Port Deposit			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (if rural give location)			
Main St				Main St			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last)				(Month) (Day) (Year)			
Blanche Krauss				Jan. 29 1956			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	10. IF UNDER 1 YEAR		
Female	White	Widowed	April 8, 1879	76	Months	Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife		Own Home		Maryland		U.S.A	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Abraham Hasson				Elizabeth Kelly			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
no						Joseph Mitchell, Port Deposit, Md	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
331X IMMEDIATE CAUSE (A)				Cerebral Hemorrhage		3 days	
ANTECEDENT CAUSE(S) DUE TO				Arterio-Sclerosis		10 yrs	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				DUE TO			
265X							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				Lraister		12 yrs	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 26, 1956, to Jan 29, 1956, that I last saw the deceased alive on Jan 29, 1956, and that death occurred at 12:30 P.M. from the causes and on the date stated above.							
SIGNATURE E. Harrison				M.D. Port Deposit, Md		DATE/SIGNED 1/30/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		7-1-1956		West Nottingham		Colons, Md	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE 1-31-1956		Drene E. Gough		J. A. Patterson & Son, Perryville, Md			

INSTRUCTIONS

TO ATTENDING PHYSICIAN FOR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

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CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH COUNTY Cecil MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) Port Deposit TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS 83 North Main St.				2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Cecil CITY (If outside corporate limits, write RURAL and give nearest town) Port Deposit TOWN STREET ADDRESS (If rural give location) 83 North Main			
3. NAME OF DECEASED (Type or Print) Chester Arthur Krauss (First) (Middle) (Last)				4. DATE OF DEATH Jan. 2 1956 (Month) (Day) (Year)			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH July 25, 1880	9. AGE last birthday 75 yrs.	IF UNDER 1 YEAR Months Days 2 19 56		IF UNDER 24 HRS. Hours Min. 2 19 56
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Track Foreman		10b. KIND OF BUSINESS OR INDUSTRY P.R.R.		11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Stephen R. Krauss				14. MOTHER'S MAIDEN NAME Anna Barr			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No (unk.)) No		16. SOCIAL SECURITY NO. 218-05-6165		17. INFORMANT & ADDRESS Chester A. Krauss Jr. Port Deposit			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) Myocarditis ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) Arterio-sclerosis (C)				18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH 1 yr = 5 yrs =			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) M.		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 14, 1955 , to Dec - 31, 1955 , that I last saw the deceased alive on Dec 31 - 1955 , and that death occurred at 9:15 M., from the causes and on the date stated above. SIGNATURE B. Benson M.D. ADDRESS (Street, city, town, state) Port Deposit, Md - DATE SIGNED Jan - 2 - 56							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 1-5-1956		NAME OF CEMETERY OR CREMATORY Hopewell		LOCATION (City, town, or county) (State) Port Deposit, Md. Rural	
24. REC'D BY REGISTRAR DATE 1-5-1956		REGISTRAR'S SIGNATURE Irene E. Dougherty		25. FUNERAL DIRECTOR'S SIGNATURE Leola Patterson & Son, Perryville, Md			

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CERTIFICATE OF DEATH

Reg. Dist. No.

492

1. PLACE OF DEATH: COUNTY <u>Cecil</u> MARYLAND CITY (If outside corporate limits, write RURAL) <u>Colora</u> LENGTH OF STAY <u>50 yrs.</u> OR and give nearest town TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MD.</u> COUNTY <u>Cecil</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Colora</u> OR TOWN STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Doctor Clark Lucas</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>Jan. 31</u> <u>1956</u>			
5. SEX. <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH. <u>September 15, 1880</u> <u>75</u> yrs	
9. AGE last birthday IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Gardener</u>		11. BIRTHPLACE (State or foreign country): <u>Floyd, Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME: <u>Jack Lucas</u>			
14. MOTHER'S MAIDEN NAME: <u>Priscilla Artizer</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>216-05-8643A</u>				17. INFORMANT & ADDRESS: <u>Mrs. Carl M. Edmondson Delta, Pa.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>						<u>1 hr.</u>	
ANTECEDENT CAUSE (B) <u>Coronary Sclerosis</u>						<u>3 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>Jan 31, 1956</u> to <u>Jan 31, 1956</u> that I last saw the deceased alive on <u>Jan 29, 1956</u> , and that death occurred at <u>11 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Dr. H. L. Taylor</u>		ADDRESS <u>M. D. R. Taylor, Md.</u>		DATE SIGNED <u>2/2/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb. 3, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Darlington Cem.</u>		LOCATION (City, town, or county) (State) <u>Darlington Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Feb 2 1956</u>		REGISTRAR'S SIGNATURE <u>L. M. Worthington</u>		24. FUNERAL DIRECTOR <u>J. Earl Tyson</u>		ADDRESS <u>Rising Sun, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

See the law for it.

ENDING PH.
copy may be
DIRECTOR
en exe.

493

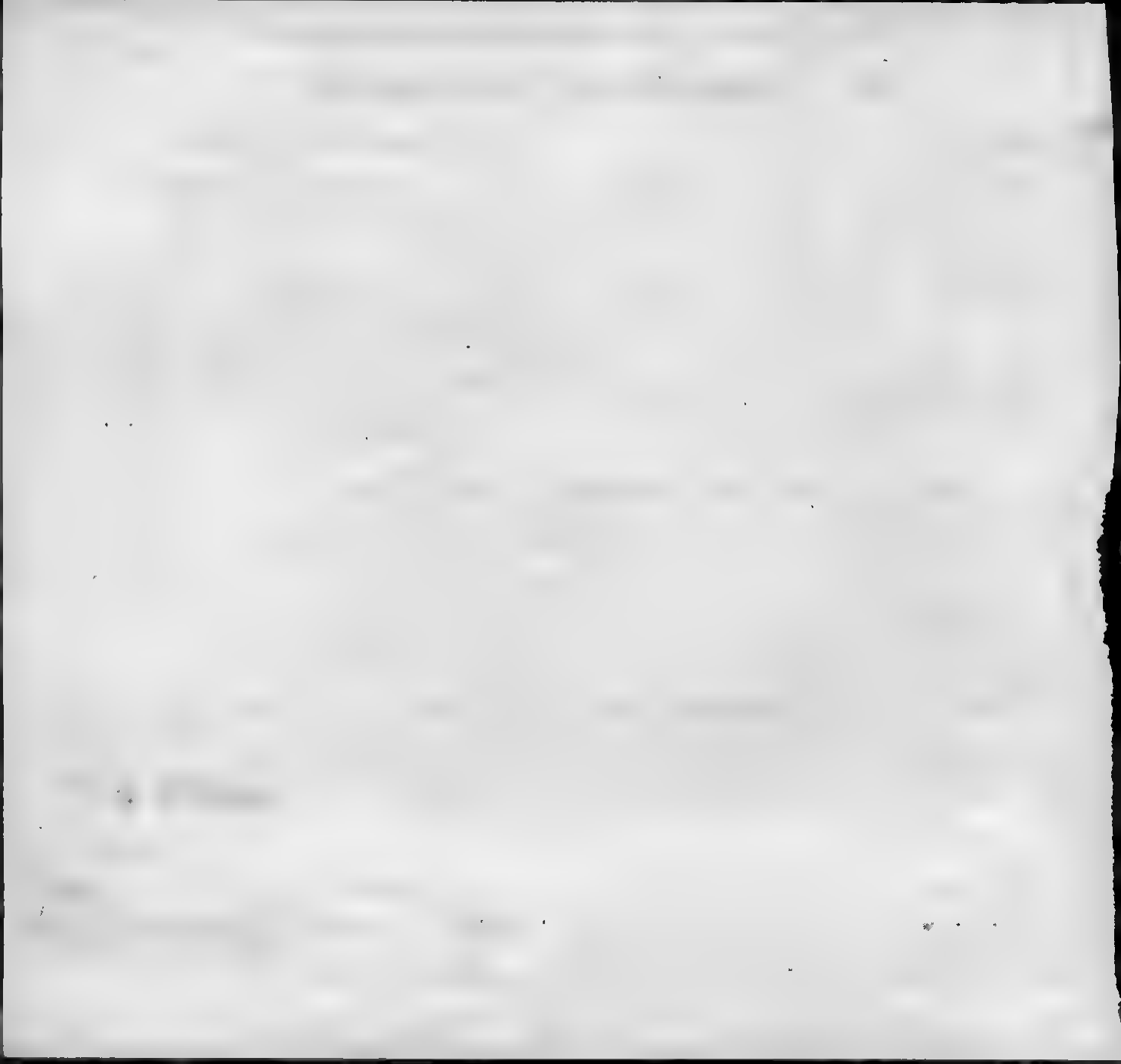
CERTIFICATE OF DEATH

Reg. Dist. No. 97

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Cecil		MARYLAND		STATE Missouri		COUNTY Taney	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Bainbridge		LENGTH OF STAY (In this place) 29 days		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Branson			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS 703 room Street			
3. NAME OF DECEASED (First) (Middle) (Last) LABEL (.) MEADOWS				4. DATE OF DEATH (Month) (Day) (Year) 18 18 19 56			
5. SEX Female		6. COLOR OR RACE Malayan		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married		8. DATE OF BIRTH 2-6-1	
				9. AGE last birthday 37 yrs.		IF UNDER 1 YEAR Months Days	
						IF UNDER 24 HRS hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Manila, Phillippine Island		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LAURENTO DE LEON				14. MOTHER'S MAIDEN NAME MAGUIR			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) ---		16. SOCIAL SECURITY NO. -----		17. INFORMANT & ADDRESS Navy Records			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
59X IMMEDIATE CAUSE (A) UREMIA				INTERVAL BETWEEN ONSET AND DEATH approx. 1 day			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(B) NEPHROSIS - CHRONIC			
				(C) HYPERTENSION - SEVERE			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		19c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYNG <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. HOW DID INJURY OCCUR?			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from 12-20, 1955, to 1-12, 1956, that I last saw the deceased alive on 1-18, 1956, and that death occurred at 3:57 P.M. from the causes and on the date stated above.							
SIGNATURE <i>H. W. Till</i>				ADDRESS (Street, city, town, state) <i>M.D. U. S. NAVAL HOSPITAL, BAINBRIDGE, MD. 1-19-56</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal & Burial		DATE THEREOF 1-19-56		NAME OF CEMETERY OR CREMATORY Branson Cemetery		LOCATION (City, town, or county) (State) Branson, Missouri	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Dorothy B. Bramble</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Eva Patterson</i>		ADDRESS <i>Russell, Mo</i>	
DATE 1-18-56							

death certificate assembly should be detached for use with transit permit.

VS A15C 1-55 10M



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

494

00482
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 94

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Becil</u>		MARYLAND		STATE <u>Ind</u>		COUNTY <u>Becil</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>North East</u>		LENGTH OF STAY (In this place) <u>3 yrs.</u>		CITY (If outside corporate limits write RURAL and give nearest town) <u>North East</u>		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Beach & Main</u>				STREET ADDRESS (If rural, give location) <u>Beach & Main St.</u>			
3. NAME OF DECEASED: (First) <u>DANIEL</u> (Middle) <u>Brosworth</u> (Last) <u>Moatz</u>				4. DATE OF DEATH (Month) <u>1</u> (Day) <u>7</u> (Year) <u>1956</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED <u>Married</u>		8. DATE OF BIRTH: <u>2-16-1901</u>	
9. AGE last birthday: <u>54</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Food Products</u>		11. BIRTHPLACE (State or foreign country): <u>Ill-Breath, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Mitchell Moatz</u>				14. MOTHER'S MAIDEN NAME:			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>235-05-8471</u>		17. INFORMANT & ADDRESS: <u>Mrs Daniel B Moatz North East Ind.</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Acute Coronary Occlusion</u> DUE TO							
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO							
stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.							
SIGNATURE <u>R. L. Dodson</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>1-1-56</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>1-5-56</u>		NAME OF CEMETERY OR CREMATORY <u>Gilpin Memorial Cemetery</u>		LOCATION (City, town, or county) (State): <u>Rehoboth Md</u>	
DATE REC'D BY LOCAL REG. <u>1-3-1956</u>		REGISTRAR'S SIGNATURE <u>Sarah C. Rothermel</u>		24. FUNERAL DIRECTOR <u>Joseph R. Grant, North East, Md</u>			

18. 10. 1944

495

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Cecil		MARYLAND		STATE (D. C.)		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN Perry Point		4yrs. 5 mo.		TOWN Washington			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
Veterans Administration Hospital				7105 Oxon Hill Road, S.E.			
3. NAME OF DECEASED:		(First) DANIEL		(Middle) L.		(Last) PATE	
4. DATE OF DEATH:		(Month) January		(Day) 9		(Year) 1956	
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: 5-3-76	9. AGE last birthday: 79 yrs.	IF UNDER 1 YEAR: Months	IF UNDER 24 HRS.: Days	IF UNDER 24 HRS.: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Guard		10B. KIND OF BUSINESS OR INDUSTRY: Government -		11. BIRTHPLACE (State or foreign country): North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Andrews Field Unknown				14. MOTHER'S MAIDEN NAME: Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes		(If Yes, give war or dates of service) S.A.W.		16. SOCIAL SECURITY NO. 218 240 008		17. INFORMANT & ADDRESS: Hospital Records, VAH, Perry Point, Md.	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						3 to 4 days	
IMMEDIATE CAUSE (A) Thrombosis left anterior cerebral artery						3 to 4 days	
DUE TO (B) Arteriosclerosis, generalized and						unknown	
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.						DUE TO cerebral, severe	
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: 2				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 8-9, 1951, to 1-9, 1956, and that death occurred at 11:50 a.m. from the causes and on the date stated above.							
SIGNATURE W. Oppler				ADDRESS VAH, Perry Point, Md.		DATE SIGNED 1-10-56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATION		LOCATION (City, town, or county) (State)	
Removal		1-10-56		Arlington National		Arlington, Va.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
1-11-56		James E. Dougherty		Pennington & Son		Havre de Grace, Md.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

496

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 96...

00484

Reg. Dist.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>leecil</i>	MARYLAND	STATE <i>md</i>	COUNTY <i>leecil</i>
CITY (If outside corporate limits write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town)	
TOWN <i>leoronungo</i>	<i>all life</i>	TOWN <i>leoronungo</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>mt Joe</i>		STREET ADDRESS (If rural, give location) <i>mt Joe</i>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <i>Joseph</i> (Middle) (Last) <i>PETERS</i>		(Month) <i>1</i> (Day) <i>10</i> (Year) <i>1956</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>Cal</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <i>Married</i>	8. DATE OF BIRTH: <i>no information</i>
9. AGE last birthday: <i>73</i> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <i>leoronungo</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>kind of work</i>	
11. BIRTHPLACE (State or foreign country): <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME: <i>Levi Peters</i>		14. MOTHER'S MAIDEN NAME: <i>Isabelle Johnson</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>no</i> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.: <i>Bertha Brown. Port Deposit, md</i>	
17. INFORMANT & ADDRESS:			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <i>44-5x Myocarditis & Hypertension</i>			
DUE TO			
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO			
stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg., etc., OF INJURY	
21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <i>A. L. Dackman</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <i>1-11-56</i>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <i>Burial</i>		DATE THEREOF <i>1-13-1956</i>	
NAME OF CEMETERY OR CREMATORY <i>mt Joe</i>		LOCATION (City, town, or county) (State) <i>Crownings, md</i>	
DATE REC'D BY LOCAL REG. <i>1-13-1956</i>		24. FUNERAL DIRECTOR <i>W. A. Patterson & Son, Perryville, Md</i>	
REGISTRAR'S SIGNATURE <i>Irene E. Daugherty</i>		ADDRESS	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

497

00485

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 97

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Cecil		MARYLAND		STATE Maryland		COUNTY Cecil	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Elkton		LENGTH OF STAY (in this place) 2		CITY (If outside corporate limits write RURAL and give nearest town) TOWN Elkton			
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital				STREET ADDRESS (If rural, give location) 325 Hollingsworth Manor			
3. NAME OF DECEASED: (Type or Print) RICHARD		(First) (Middle) (Last) RUDY PROPPS, JR.		4. DATE OF DEATH		JAN 2 19 56	
5. SEX: Male		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single		8. DATE OF BIRTH: 4-16-55	
9. AGE last birthday: yrs. 0		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		11. BIRTHPLACE (State or foreign country): Sainbridge, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME: Richard Rudy Propps, Sr.		14. MOTHER'S MAIDEN NAME: Geraldine GRIFFIN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: Navy Records			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) BRONCHOPNEUMONIA & H. A. HOUSE-HELDERS.							
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>. SIGNATURE <i>R. W. Jackson</i> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <i>1-3-56</i> M. D. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM.							
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Removal		1-2-56		Cecil Manor Cemetery		Elkton Maryland	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS			
1-2-56		<i>Bartholomew B. Bramble</i>		<i>Propps Funeral Home Elkton, Md</i> <i>B. 277</i>			

RECEIVED

JAN 5 1950

BUREAU W. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH COUNTY Cecil MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Elkton LENGTH OF STAY (In this place) 16 days HOSPITAL OR INSTITUTION OR STREET ADDRESS Union Hospital-Elkton		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Cecil CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN E North East STREET ADDRESS (If rural give location) Elkton Cecil Avenue	
3. NAME OF DECEASED: (Type or Print) Maude Leedom Rose		4. DATE (Month) (Day) (Year) OF DEATH: Jan. 28, 19 56	
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify): Widow	8. DATE OF BIRTH: Oct 20, 1874
9. AGE last birthday: 81 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife	11. BIRTHPLACE (State or foreign country): Bay View Cecil Co Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME: Edward T. Leedom	
14. MOTHER'S MAIDEN NAME: Mary Tyson		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No	
16. SOCIAL SECURITY No. 212-24-7535		17. INFORMANT & ADDRESS: Francis Rose North East, Md	
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) Respiratory and Cardiac failure ANTECEDENT CAUSE (B) Carcinoma of lungs DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Pleural effusion			INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Pleural effusion			
19A. DATE OF OPERATION: C		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Jan. 6, 19 56 to Jan 28, 19 56, that I last saw the deceased alive on Jan 28, 19 56, and that death occurred at 11 A M, from the causes and on the date stated above. SIGNATURE Arthur Centurion ADDRESS North East, Md. DATE SIGNED Jan 28/56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) 10 unaid		24. FUNERAL DIRECTOR ADDRESS Joseph R. Lusk North East Md	
DATE REC'D BY LOCAL REGISTRAR Jan 30		REGISTRAR'S SIGNATURE J. R. Lusk	

RECEIVED

FEB 1 1947

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

00487

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 91

1. PLACE OF DEATH COUNTY <u> Cecil </u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u> Delaware </u> COUNTY <u> N. C. </u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u> Warwick </u> LENGTH OF STAY (in this place) <u> 1 day </u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u> Townsend, Rural </u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) <u> Benedict </u> (Middle) <u> C. </u> (Last) <u> Savin </u>		4. DATE OF DEATH (Month) <u> 1 </u> (Day) <u> 5 </u> (Year) <u> 1956 </u>	
5. SEX <u> Male </u>	6. COLOR OR RACE <u> White </u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u> Single </u>	8. DATE OF BIRTH <u> 3-16-1902 </u>
9. AGE last birthday <u> 53 </u> yrs.		10. BIRTHPLACE (State or foreign country) <u> Ind. </u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u> James Savin </u>		14. MOTHER'S MAIDEN NAME <u> Mary Ann Holden </u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u> Margaret Savin Middletown Del. </u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u> Atrial Fibrillation </u>		
Antecedent cause(s) (b) <u> Coronary Artery disease </u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>

21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
SUICIDE HOMICIDE	INJURY			
TIME (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		
OF INJURY				

22. I hereby certify that I attended the deceased from Jan. 5, 1955 , to Jan 5, 1956 , that I last saw the deceased alive on Jan 5, 1956 , and that death occurred at 11 A.M. from the causes and on the date stated above.

SIGNATURE Harvey L. Koch, M.D. ADDRESS 106 S. Broad Street, Middletown Del. DATE SIGNED 1/7/56

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u> Burial </u>	<u> 1-8-56 </u>	<u> Warrenton Cemetery </u>	<u> Warrenton Ind. </u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u> January 7-1956 </u>	<u> Mrs. Ralph H. Bell </u>	<u> G. Jack Daniels </u>	<u> Middletown Del. </u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

S. A. S. 1001

RECEIVED

499

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY Cecil MARYLAND			STATE Maryland COUNTY		
CITY (If outside corporate limits, write RURAL and give nearest town) LENGTH OF STAY (in this place) TOWN Perry Point 7 mo. 19 days			CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore		
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hospital			STREET ADDRESS (If rural give location) 428 N. Gilmore		
3. NAME OF DECEASED: (First) (Middle) (Last) EUGENE (NMI) SHAW			4. DATE (Month) (Day) (Year) OF DEATH: January 25 19 56		
5. SEX: Male	6. COLOR OR RACE: Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: 11-20-92	9. AGE last birthday 63 yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Head Waiter		10B. KIND OF BUSINESS OR INDUSTRY: Mess Hall - V.A.		11. BIRTHPLACE (State or foreign country): North Carolina	
13. FATHER'S NAME: Hospital Ephraim Shaw - Deceased		12. CITIZEN OF WHAT COUNTRY? USA			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS: Hospital Records, VAH, Perry Point, Md.	
18. MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
IMMEDIATE CAUSE (A) Peritonitis diffuse					7 to 10 days
ANTECEDENT CAUSE (S) (B) Carcinomatosis with rupture of the small bowel					unknown
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C) Carcinoma of the head of the pancreas					unknown
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Pulmonary congestion and edema					3 to 4 days
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY VA M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 6-6, 1955, to 1-25, 1956, and that death occurred at 9:40pm, from the causes and on the date stated above.					
SIGNATURE W. OPPLER, Director, Professional Services			DATE SIGNED D. V.A. Hospital, Perry Point, Md. 1-26-56		
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		DATE THEREOF 1-26-56		NAME OF CEMETERY OR CREMATORY Baltimore National	
				LOCATION (City, town, or county) (State) Baltimore, Md.	
DATE REC'D BY LOCAL REGISTRAR 1-27-56		REGISTRAR'S SIGNATURE James E. Dougherty		24. FUNERAL DIRECTOR Perry Point, Md. de Grace, Md.	

MARGIN RESERVED FOR BINDING

VS. A15 - 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 30 1951

151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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00489

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 92

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Cecil</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (to this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR		TOWN	
<input checked="" type="checkbox"/> TOWN <u>Elkton</u>		<u>3 yrs.</u>		<u>Elkton Rural</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Dogwood Road.</u>				STREET ADDRESS (If rural, give location) <u>Dogwood Road.</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH			
(First) <u>GUYLES</u>		(Middle)		(Last) <u>SOULE</u>		(Month) (Day) (Year) <u>1 31 19 66</u>	
5. SEX: <u>M.</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>Sept 17, 1919</u>		9. AGE last birthday: <u>36</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Mechanics</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Saw Sharpens</u>		11. BIRTHPLACE (State or foreign country): <u>Linden, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Herbert E Soule</u>				14. MOTHER'S MAIDEN NAME: <u>Grand Baker</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Pippin Funeral Home Elkton Md</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) ... <u>Charred Body.</u>							
DUE TO							
Antecedent cause(s) (b) ...							
Diseases or conditions, if any, giving rise to the above cause DUE TO							
stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. PLACE (Home, farm, factory, OF street, public bldg., etc.) INJURY <u>Home</u>		21c. (City or town) (County) (State) <u>Elkton Cecil Md</u>			
21d. TIME (Month) (Day) (Year) OF INJURY <u>1 31 56</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Overheated Stove Set fire to shack.</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>A. C. Doelner</u>				M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <u>1-31-56</u>			
23. BURIAL CREMATION, REMOVAL (Specify): <u>Buried</u>		DATE THEREOF: <u>Feb. 1 1956</u>		NAME OF CEMETERY OR CREMATORY: <u>West Canton N.Y.</u>		LOCATION (City, town, or county) (State): <u>West Canton N.Y.</u>	
DATE REC'D BY LOCAL REG. <u>Feb 1</u>		REGISTRAR'S SIGNATURE: <u>JR. Trazar</u>		FUNERAL DIRECTOR: <u>Pippin Funeral Home</u>		ADDRESS: <u>Elkton Md.</u>	

1000

1000

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 96

501

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Cecil		MARYLAND		STATE D.C.		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		STREET ADDRESS (If rural give location)	
X Perry Point,		2 mo. 27 days		Washington		478-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		Veterans Administration Hospital		STREET ADDRESS		5200 Kansas Avenue, N.W.	
3. NAME OF DECEASED: (Type or Print)		(First) LAWRENCE		(Middle) U.		(Last) TRUMBULL	
4. DATE OF DEATH:		(Month) January		(Day) 13		(Year) 1956	
5. SEX: Male		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Divorced		8. DATE OF BIRTH: 12-4-95	
9. AGE last birthday 60 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk		11. BIRTHPLACE (State or foreign country): Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Frank Trumbull (Deceased)				14. MOTHER'S MAIDEN NAME: Aurglia Curtis (Deceased)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) Yes WW-1				16. SOCIAL SECURITY NO. Unknwon		17. INFORMANT & ADDRESS: Hospital Records, VAH, Perry Point, Md.	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Hemorrhage from cerebral vessels						2 Minutes	
DUE TO due to Trauma (Electric Shock)							
ANTECEDENT CAUSE (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Arteriosclerotic Cardiovascular Disease						10 Years	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY VA M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 10-17, 1955 , to 1-13, 1956 , and that death occurred at 9:05 AM , from the causes and on the date stated above.							
SIGNATURE Joseph C. Grasperger, Acting Chief,				ADDRESS VAH, Perry Point, Md.		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Removal		1-13-56		Arlington National		Arlington, Virginia	
DATE REC'D BY LOCAL REGISTRAR 1-13-56		REGISTRAR'S SIGNATURE Irvene E. Dougherty		24. FUNERAL DIRECTOR W.W. CHAMBERS, 1400 Chapin St, N.W.		ADDRESS Wash., D.C.	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. C.

JAN 17 1950

RECEIVED

512

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY CECIL		MARYLAND		STATE MARYLAND COUNTY BALTIMORE			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN PERRY POINT		7 DAYS		OR TOWN BALTIMORE			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hospital				STREET ADDRESS (If rural give location) 602 N. CARROLLTON AVENUE			
3. NAME OF DECEASED: (First) JOHN		(Middle) HENRY		(Last) WALKER		4. DATE (Month) (Day) (Year) OF DEATH January 20, 1956	
5. SEX. Male	6. COLOR OR RACE: Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married	8. DATE OF BIRTH: May 5, 1895		9. AGE last birthday 60 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waiter		10B. KIND OF BUSINESS OR INDUSTRY: RR Dining Car		11. BIRTHPLACE (State or foreign country): Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: George Walker				14. MOTHER'S MAIDEN NAME: Margaret Nelson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes		16. SOCIAL SECURITY NO. 719 07 0641		17. INFORMANT & ADDRESS: Hospital Records, VAH., Perry Point, Md.			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Bronchopneumonia, bilateral unresolved				2 to 3 days			
ANTECEDENT CAUSE (S) (B) Myocardial fibrosis				Unknown			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Coronary Sclerosis				Unknown			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Arteriosclerosis, generalized, severe				Unknown			
19A. DATE OF OPERATION: 2		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) OF INJURY VA		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan. 13, 1956 , to Jan. 20, 1956 , and that death occurred at 6:15 P.M. , from the causes and on the date stated above.							
SIGNATURE E. S. Ellis, M.D., Acting Director				ADDRESS		DATE SIGNED 1-21-56	
E. S. ELLIS, M.D., Professional Service.				M. D. VAH, Perry Point, Md.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) REMOVAL		DATE THEREOF 1-22-56		NAME OF CEMETERY OR CREMATORY Arlington National		LOCATION (City, town, or county) (State) Ft. Myer, Virginia.	
DATE REC'D BY LOCAL REGISTRAR 1-24-56		REGISTRAR'S SIGNATURE James E. Dougherty		24. FUNERAL DIRECTOR PLANNINGTON & SON		ADDRESS Havre DeGrace, Md.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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RECEIVED

503

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Cecil</u>	MARYLAND	STATE <u>Md</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Perryville</u>	LENGTH OF STAY (in this place) <u>4 yrs 26 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>VA Hospital</u>	STREET ADDRESS (If rural give location) <u>320 Radnor Road</u>		
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>Paul</u>	(Middle) <u>R.</u>	(Last) <u>Waller</u>	(Month) <u>January</u> (Day) <u>7</u> (Year) <u>1956</u>
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>12-20-94</u>
9. AGE last birthday: <u>61</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Agent</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Insurance</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Richard Waller</u>		14. MOTHER'S MAIDEN NAME: <u>Ellen Rider</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service) <u>Yes</u> <u>WWI</u>		16. SOCIAL SECURITY NO. <u>212-07-2933</u>	
17. INFORMANT & ADDRESS: <u>Hospital Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(A) <u>Bronchopneumonia</u>		<u>3 days</u>	
(B) <u> </u>		<u> </u>	
(C) <u> </u>		<u> </u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u> </u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 9</u> , 1951, to <u>Dec 9</u> , 1951, and that death occurred at <u>10:30 AM</u> from the causes and on the date stated above.			
SIGNATURE <u>William M. Harris M.D.</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-7-56</u>	
NAME OF CEMETERY OR CREMATORY <u>New Freedom, Pa.</u>		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REGISTRAR <u>1-8-56</u>		REGISTRAR'S SIGNATURE <u>Jane E. Daugherty</u>	
24. FUNERAL DIRECTOR <u>Jenkins Funeral Home, Balt., Md.</u>		ADDRESS <u>Howard R. McCone, Jr.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

JOHN V. S.

475

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Cecil</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Cecil</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
21 TOWN <i>Elkton</i>	1 day	TOWN <i>Childs</i>	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
65 <i>Union Hospital</i>		<i>1</i>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <i>Ella</i>	(Middle)	(Last) <i>White</i>	DATE OF DEATH: <i>Jan. 24 1956</i>
(Type or Print)			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:
<i>Female</i>	<i>White</i>	<i>Married</i>	<i>April 20 1906</i>
9. AGE last birthday		IF UNDER 1 YEAR IF UNDER 24 HRS.	
<i>49 yrs.</i>		Months	Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	
<i>Homemaker</i>			
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<i>Virginia</i>		<i>U.S.A.</i>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<i>Andy Andrews</i>		<i>Lucy Hester</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		15. SOCIAL SECURITY No.	
		<i>—</i>	
16. MEDICAL CERTIFICATION		17. INFORMANT & ADDRESS:	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		<i>Robert C. White</i>	
IMMEDIATE CAUSE (A) <i>Broncho-pneumonia</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1/2</i>	
ANTECEDENT CAUSE (B) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Cerebral Thrombosis</i>			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>1954</i> , to <i>Jan 24, 1956</i> , that I last saw the deceased alive on <i>Jan 22, 1956</i> , and that death occurred at <i>11:30</i> M, from the causes and on the date stated above.			
SIGNATURE <i>Donald H. Drexler</i>		DATE SIGNED <i>Jan 24, 1956</i>	
M.D.		ADDRESS <i>Elkton, Md.</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
<i>Burial</i>		<i>Union Cemetery</i>	
DATE REC'D BY LOCAL REGISTRAR		LOCATION (City, town, or county) (State)	
<i>Jan 25</i>		<i>Elkton (Rural) Md.</i>	
REGISTRAR'S SIGNATURE <i>JR Fraser</i>		24. FUNERAL DIRECTOR ADDRESS	
		<i>Joseph R. Grant North East, Md.</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 27 1956

BUREAU V. S.

476

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>CECIL</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>CECIL</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>		LENGTH OF STAY (in this place) <u>2 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>		OR TOWN <u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Union Hospital</u>				STREET ADDRESS (If rural give location) <u>RFD #3</u>			
3. NAME OF DECEASED: (First) <u>KAREN</u> (Middle) <u>S.</u> (Last) <u>WOODIE</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>1</u> <u>5</u> <u>1956</u>			
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Child</u>	8. DATE OF BIRTH: <u>May 2, 1954</u>	9. AGE last birthday: <u>1</u> yrs. <u>8</u> Months <u>2</u> Days <u></u> Hours <u></u> Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Child</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Elkton, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Junior V. Woodie</u>				14. MOTHER'S MAIDEN NAME: <u>Louise B. Lerena</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Junior V. Woodie RFD #3 Elkton</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>ACUTE METABOLIC ACIDOSIS</u>						<u>24 hours</u>	
ANTECEDENT CAUSE (B) <u>ACUTE GASTRO-ENTERITIS</u>						<u>48 hours</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>? Undermined infection?</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Nutritional anemia</u>						<u>Four months</u>	
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1.3</u> , 1956, to <u>1.5</u> , 1956 that I last saw the deceased alive on <u>1.5</u> , 1956, and that death occurred at <u>7:45 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Peter Shukis</u>				ADDRESS <u>154 W. MAIN, ELKTON, MD.</u>		DATE SIGNED <u>1.6.56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>Jan 7, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>White Top</u>		LOCATION (City, town, or county) (State) <u>Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Jan 6</u>		REGISTRAR'S SIGNATURE <u>JR. Scager</u>		24. FUNERAL DIRECTOR <u>Peyperi General Home</u>		ADDRESS <u>Elkton, Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 9 1956

RECEIVED